Application/Policy No.

Superior Health Cover - Claim Form

Important information you must read before submitting this claim

- **A GP referral letter must be attached to this claim form**
- **An estimate of costs must be attached to this claim form for surgical procedures**
- **Claims must be submitted within 12 months from the date of treatment.**

Are you applying for prior approval? Yes ☐ No ☐

Prior approval requires five working days to be processed, provided all requested information is submitted.
Please be aware that it may be necessary to request further information before completing the assessment of your claim.

1. Policy Owner

Title **First Names** **Surname**

Street Address

Suburb **Town/City** **Postcode**

Postal Address **(if different from street address)**

Suburb **Town/City** **Postcode**

Phone No. Business ( ) Home ( ) Mobile ( )

Email **Fax No.** ( )

Date of Birth / /

2. Claimant (if claimant is not the Policy Owner)

Title **First Names** **Surname**

Street Address

Suburb **Town/City** **Postcode**

Postal Address **(if different from street address)**

Suburb **Town/City** **Postcode**

Phone No. Business ( ) Home ( ) Mobile ( )

Email **Fax No.** ( )

Date of Birth / /

3. Claim Details

Details of the condition or symptoms which has resulted in this claim (please be specific).

Have you claimed for this condition previously? Yes ☐ No ☐

When did you first have symptoms?

When did you first seek medical advice?

Provide details of the investigation/treatment performed/to be performed.

Date of Admission / / Date of discharge / /

Please turn over.

Please supply the name and contact details of your doctor who holds your medical records. (Please be aware that it may be necessary to request further information before completing the assessment of your claim.)

Is this work or accident related? Yes ☐ No ☐ ACC reference number

4. Receipt/Invoice Details

Date of Treatment	Provider's Name	Condition Treated	Pay Provider (please tick)	Pay Client (please tick)	Amount
				Total Value ($)	

5. Direct Credit Details (should your claim be accepted)

Which bank account would you like your claim paid into?

☐ Same bank account as the one my premium is paid from

☐ A different bank account:

Name of account

Bank account number ☐☐ – ☐☐☐☐ – ☐☐☐☐☐☐☐ – ☐☐☐

Statement of Disclosure

1. This claim form collects personal information about you which will be used to: (a) investigate and determine the validity of your claim; (b) confirm the information in your application for this insurance product; (c) maintain relevant statistical records.
2. This information is collected and held by AIA New Zealand at 5-7 Byron Avenue, Takapuna, North Shore City 0740, New Zealand.
3. You have a duty to provide AIA New Zealand with all the facts material to your claim and all information, which we may reasonably require in relation to your claim. If you fail to provide this information we may not pay your claim. If you provide false information this may result in your policy being voided from inception or cancelled.
4. Under the Privacy Act 1993 and Health Information Code 1994, you have the right of access to, and correction of, any information held or provided.

Declaration and Authority to Obtain and Use Information

1. I authorise any doctor, medical specialist, hospital, clinic, insurance company, ACC, employers or any other authority to disclose to AIA New Zealand any and all information concerning my medical history. A photocopy or facsimile of this authorisation shall be as valid as an original.
2. I have read and understood the information in this claim form including the section above relating to the Privacy Act 1993 and the Health Information Privacy Code 1994.
3. I declare that all information provided by me relating to this claim is true and correct, and no material information has been withheld.
4. I am authorised by each member named on this form to complete and sign on their behalf.

Declaration

I declare that the answers to the above questions are true and correct.

Full Name of Policy Owner	Signature of Policy Owner	Date

Full Name of Claimant	Signature of Claimant	Date

(To be signed by the parent/legal guardian if claimant is a child under 16 years.)

Checklist

Please ensure all the relevant information is supplied to enable us to assess your claim:

☐ Referral letter from GP or medical practitioner (please attach to claim form)

☐ Medical report and estimate of costs from a specialist if hospitilisation is required (please attach to claim form)

☐ ACC letter of acceptance/decline for any accidental/injury related claim

☐ Original copies of invoices/receipts

☐ All sections of the claim form are completed in full, including the Privacy Act and Health Information Code declaration.

Please return completed claim form with relevant documentation to the address below, email: it to nz.claims@aia.com or fax to 0800 181 234.

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